

SOLIRIS (ECULIZUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD-10 CODE

Atypical Hemolytic Uremic Syndrome (aHUS) ICD-10 Code: _____
 Myasthenia Gravis (gMG) ICD-10 Code: _____
 Paroxysmal Nocturnal Hemoglobinuria (PNH) ICD-10 Code: _____
 Neuromyelitis Optica Spectrum Disorder (NMOSD) ICD-10 Code: _____
 Diagnosis: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

This signed order form by the provider Labs and Tests supporting primary diagnosis
 Patient demographics AND insurance information Antibody results (if applicable): Anti-AQP4 for NMOSD, AChR for gMG
 H&P and Clinical/Progress notes supporting primary diagnosis Documentation of meningococcal vaccines

Is the ordering PROVIDER enrolled in the Ultomiris and Soliris REMS program? Yes No (must be enrolled to start therapy)
 Is your patient enrolled in the Soliris REMS program? Yes No (must be enrolled to start therapy)

List tried & failed therapies:

1)
2)

MEDICATION ORDERS

Loading Dose Soliris _____mg IV once weekly for 4 weeks, followed by _____mg IV at week 5 and every 2 weeks thereafter
 Soliris _____mg once weekly for _____weeks, followed by _____mg IV at week _____

Maintenance Dose Soliris _____mg IV every 2 weeks Soliris _____mg IV every _____weeks

Refills*: X 6 months X 1 Year _____ doses Other: _____

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATION ORDERS

Acetaminophen 650mg PO prior to infusion Other: _____
 Diphenhydramine 25mg PO prior to infusion Other: _____

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive
 Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____